STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 17,132
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision of the Department of Prevention, Assistance, Transition, and Health Access (PATH) denying her request for a "pool pass" to do water physical therapy under the provisions of the Medicaid program, the M108 exception provisions, and the General Assistance medical emergency program.

FINDINGS OF FACT

1. The petitioner is a forty-six-year-old woman who is disabled due to bipolar disease and lives on SSI payments of $633 per month. She is being treated for a spinal condition for which she received aquatic physical therapy covered by Medicare until April of 2001. The therapy stopped following a finding that she was making no rehabilitative progress with regard to her spinal condition.

2. The petitioner asked the Department to fund her pool visits following this cut off. Her request was supported by her primary physician who said that she suffered from

intractable sciatica caused in part by her disc disease and that swimming in the pool was the only therapy that had helped her. He also noted that she walks with a limp and uses a cane and that she needed swimming to improve her ambulation. The Department denied her under its regulations as written and told her that the Medicaid exception process was not available to her because she was requesting a “covered service."

3. After several status conferences which concerned the actual nature of the petitioner’s request (was it for the provision of physical therapy services or merely swimming in a pool following recommendations of a physical therapist?) and the availability of the M108 process, it was suggested to the petitioner that she get further evidence from some specialists with whom she had an upcoming appointment.

4. The petitioner was seen by a physician who specializes in the spine and a physical therapist who works with her. The petitioner provided the Department with letters from both of these persons dated October 18, and November 5, 2001. Both of these health professionals agree that the petitioner walks with great difficulty (she often uses a wheelchair), has a limited range of motion in her spine and is in chronic pain. An MRI has confirmed that she has a bulging disc at the L4-5 level although this diagnosis does not

completely explain all of her symptoms. Both of these professionals have recommended that the petitioner swim in a pool in order to maintain a level of muscle conditioning and functioning and to relieve the pain and pressure on her back. It is the only rehabilitation modality which she can tolerate. Both are concerned that she has developed lower extremity weakness with increasing functional limitations. In the words of her physical therapist “unless she remains active and exercises in the pool, it is very likely that she will continue to become more and more disabled and eventually require nursing home admission. These opinions are found to be credible and are adopted herein as fact. It was recommended that she attend a “physical therapy supervised pool program."

5. In the meantime, the Department obtained a written report from the physical therapists who had been assisting the petitioner during her Medicare coverage stating that "hands on" physical therapy had not succeeded in rehabilitating her back problem and recommending that she be placed on a program of self-managed exercises given to her by a physical therapist. They are willing to take her into the unskilled pool program which provides pool access only for a certain hourly fee. The purpose of such a program would be to

maintain her strength and conditioning, not to rehabilitate her spine. It was noted that the petitioner received some relief from pain in the pool but it did not carry over for long once she was out of the pool.

6. Due to some miscommunication within the Department, no action was taken on the reports sent by her therapists for several weeks. A January 8, 2002 letter sent by the Department to the petitioner made it appear that no information had yet been received from the physical therapist who had seen her. At a status conference on February 1, the petitioner, who has trouble understanding what is going on and is often assisted by an aide, said the documents had been supplied.

7. The Department recovered the documents and did an "M106" prior approval decision dated February 12, 2002 which continued to deny services to her because they would not be covered by a licensed physical therapist. The hearing officer was provided with the letters of support from her physicians. The letter from the physical therapist was not clear as to whether she was recommending physical therapist whether she was requesting licensed physical therapy services or just a pool pass to do recommended exercises. A letter was sent to her asking for clarification. In the meantime, to attempt to

expedite a process that had already gone on too long, PATH was urged to proceed with the M108 review which it now agreed was available to the petitioner. The petitioner was also advised of the availability of emergency treatment under the General Assistance program since the records had shown that she was in pain.

8. The petitioner applied for General Assistance on March 1, 2002 and was denied because “it is not the kind of medical care covered under GA." She was referred to the Department for a Medicaid exception under "M108."

9. PATH did the M108 review on March 11, 2002 and determined to deny the request for the exception. A copy of that review is attached as Exhibit No. One. She was denied based on a finding that her condition is “not unique” because many people have back pain caused by injured discs that require a structured pain management regimen. Although the review acknowledged the reports of her treaters that she was deteriorating and would end up in a nursing home, it concluded that there were “no serious detrimental health consequences noted to occur if she does not receive the pool pass." The final reason for denial is that exercise in a pool is not primarily medical in nature and is useful to persons in the absence of disease. No explanation was offered as to why that

was a particular problem in this case since the petitioner was planning to use the pool pass for medical rather than recreational purposes. It was suggested that pharmacological interventions and pain management clinics are covered alternatives for the petitioner's pain relief. However no mention was made as to whether such interventions had been recommended as advisable in her case, would be effective or were less economical than the pool pass.

10. On March 22, 2001, the physical therapist clarified that she was asking for non-skilled aquatic exercise in a pool as prescribed by a physical therapist. She reiterated again that she felt such a pass was needed to help maintain the petitioner's current fitness level and functional status and enable her to live in her own home. She agreed that the supervision of a physical therapist was not needed and was not requested.

ORDER

The decision of the Department is reversed as to the M108 denial.

REASONS

Regulations adopted in the Medicaid program limit the provision of physical therapy as a home health service to those services which are “of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required." Medicaid Manual (M) 710.4. Physical therapy is also covered as an outpatient hospital service. M520. However, Medicaid regulations limit payment for any covered services to “specified practitioners licensed by the appropriate licensing agency of the State." M600.

The petitioner is not requesting that a licensed physical therapist attend her and assist her with exercises. The evidence is that a physician and physical therapist have prescribed exercises for the petitioner which she already knows how to perform without supervision. The problem is that the petitioner cannot perform these exercises unless she can get access to a pool. It appears in her area that the only way she can get access to a pool is to be part of the local hospital’s outpatient pool physical therapy program. The Department says, correctly, that there is no provision of its Medicaid regulations which authorizes payment for access to the pool absent the provision of services by a licensed physical therapist. Therefore, the denial of prior approval

(under M106) for this item is justified by the Department's regulations.

The Department has adopted a regulation whereby non-covered services can be paid for as an "exception" to the Medicaid coverage regulations under a procedure adopted by the Department which provides, in pertinent part, as follows:

> Procedure for Requesting Coverage of a Service or Item
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> Any beneficiary may request that the department cover a service or item that is not already included on a list of covered services and items . . .
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> Each decision shall result in one of four outcomes. The four possible outcomes are: (1) the commissioner approves coverage of the service or item for the individual and adds it to a list of pre-approved services or items; (2) the commissioner approves coverage of the service or item for the individual and does not add it to a list of pre-approved services or items; (3) the commissioner does not approve coverage of the service or item for the individual and adds it to a list or pre-approved services or items; or (4) the commissioner does not approve coverage of the service or item for the individual and does not add it to a list of pre-approved services or items.
>
> . . . An adverse decision from the commissioner may be appealed through the fair hearing process.
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> If, under this section, an individual requests that a service or item be covered, the following criteria will be considered, in combination, in determining whether to cover the service or item for the individual and/or to add it to a list of pre-approved services or items, with the following exception. If the service or item is subject to FDA approval and has not been approved (criterion #9 below), the request for coverage of the service or item will be denied.

1. Are there extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service or item were not provided?

2. Does the service or item fit within a category or subcategory of services offered by the Vermont Medicaid program for adults?

3. Has the service or item been identified in rule as not covered, and has new evidence about efficacy been presented or discovered.

4. Is the service or item consistent with the objectives of Title XIX?

5. Is there a rational basis for excluding coverage of the service item? The purpose of this criterion is to ensure that the department does not arbitrarily deny coverage for a service or item. The department may not deny an individual coverage for a service or item solely based on its cost.

6. Is the service or item experimental or investigational?

7. Have the medical appropriateness and efficacy of the service or item been demonstrated in the literature or by experts in the field?

8. Are less expensive, medically appropriate alternatives not covered or not generally available?

9. Is FDA approval required, and if so, has the service or item been approved?

10. Is the service or item primarily and customarily used to serve a medical purpose, and is it generally not useful to an individual in the absence of an illness, injury, or disability?

Medicaid Manual (M)108

The M108 review by PATH as noted in the findings lacked an analysis and answer to several of these questions. The Department failed to discuss why a 46-year-old person who is already deteriorated to the point where she limps and must use a cane and wheelchair is not unique among persons who have back pain and injured discs. It also failed to discuss why a person with decreasing mobility whose only modality to maintain strength and function is swimming will not suffer a detrimental health consequence without access to a pool. In addition, it did not explain why the fact that access to a pool can be used for a non-medical purpose, (i.e. recreation) is relevant here. The petitioner clearly is planning to use the pass for access to a pool therapy program which is strictly medical in nature in her case.[1] And finally, there is no evaluation of the relative cost-effectiveness of this treatment compared with drug intervention and potential nursing home care.

The Board has said in the past that the Department has considerable discretion in making these decisions under M108. Fair Hearing No. 16,223. However, that discretion is not

[1] If the Department takes the position that possible other non-medical uses of the service is disqualifying, it should list this as criteria as number one with no further need to consider any other factors. These criteria

unfettered. The Supreme Court has established a "clearly erroneous" standard in determining whether M108 decisions are to be upheld or not. Cameron v. Department of PATH, Supreme Court Docket No. 2000-339, August 23, 2001, p. 3.

The Department's decision in this matter is clearly erroneous because it has failed to consider pertinent facts and to answer questions required by its own process. In order for the Department to be upheld in its decisions, it must show that a meaningful review, not a pro forma one, has occurred. In this case the Department drew conclusions that appear quite incongruous with the facts before it without any explanation. The Department may have had some supportable reason for drawing these conclusions but it is has not been made apparent in the decision. The result appears completely arbitrary and is thus erroneous.

The petitioner has presented facts which would justify an exception to the Medicaid regulations. Since the Department's unsupported decision is clearly erroneous, the Board may reverse it and grant the petitioner's request for a pool pass.[2]

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are, under the Department's regulation supposed to be "considered" which contemplates some analysis of its importance in the case.

[2] As this matter has taken an unconscionably long time to come forth for decision, mostly due to internal Departmental mistakes and requests for

As the petitioner has made out a case for receipt of these benefits under the M108 program, it is not necessary to consider whether her request should have been covered under the General Assistance program.

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further time, any further remand for reconsideration would be unjust to the petitioner.